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TB Risk Assessment Annual Review

Name _____ DOB _____

Program _____

**Have you ever had a reaction to a TB test? ○ Yes ○ No

TB EXPOSURE RISK

1.	Were you a temporary or permanent resident for one month or more in a country with a high TB rate? (Any country other than U.S., Canada, Australia, New Zealand, and those in Northern Europe or Western Europe).	○ Yes	○ No
2.	Are you currently or plan to be immunosuppressed – including HIV infection, organ transplant recipient, treatment with a TNF-alpha antagonist, chronic steroids (>15mg prednisone per day for > 1 month) or other immunosuppressive medication?	○ Yes	○ No
3.	Have you been in close contact with someone who had infectious TB disease since your last TB test?	○ Yes	○ No

TB SYMPTOM REVIEW Since your last screening, have you experienced any of the following?

1.	Cough or chest pain that lasted longer than 3 weeks	○ Yes	○ No
2.	Fever that lasted longer than 3 weeks	○ Yes	○ No
3.	Coughing up blood	○ Yes	○ No
4.	Excessive sweating at night	○ Yes	○ No
5.	Unexplained weight loss	○ Yes	○ No
6.	Unexplained increase in weakness/fatigue	○ Yes	○ No

If you answered "**No**" to any of the numbered questions, **no further testing or action is required**. Please sign and submit to Campus Health.

If you answered "**Yes**" to any of the numbered questions, you **are required** to have a PPD skin test or TB blood test.

_____ _____
Student Signature Date

_____ _____
NMC Reviewer Date

For Provider Use Only: TB Skin Test

Date & time TB placed: _____ Site: LFA RFA Date & time TB read: _____
(within 48-72 hours)

Placed by: _____ Read by: _____
Healthcare Provider Healthcare Provider

Lot #: _____ Results: _____mm

Exp. Date: _____ Interpretation (circle result): Positive Negative